Stacey Anderson
Planned Parenthood of Montana
SB 142 – OPPOSE

BUSINESS & LABOR
EXHIBIT NO. 4
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BILL NO. SB142

Mr. Chairman, members of the Committee, my name is Stacey Anderson. I am the Public Affairs Director for Planned Parenthood of Montana. As the largest provider for reproductive healthcare in Montana – with 22,000 patients, we oppose SB 142.

Women have distinct health care needs. Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. And while there seems to be an undefined reproductive healthcare exemption in this bill, it ignores the fact that women are also more likely to have chronic conditions that require continuous healthcare treatment, more prescription drugs on average, and certain mental health considerations that affect twice as many women as men.

Health insurance is a critical factor in making health care accessible, but women face unique barriers to obtaining coverage that is affordable. The relationship between health insurance coverage status and access to health care is well-documented. Yet, 18 percent of all women in the United States are uninsured. Even women who have insurance are more likely than men to be underinsured, with insufficient coverage unless they purchase expensive "policy riders" such as maternity care to meet their needs – which in Montana costs an additional $24,807 over the course of a woman's reproductive lifetime (18-50). Women are less likely to have access to health insurance through their own jobs and are more likely to depend on their spouse's employer-provider coverage or purchase individual market coverage directly from insurers. Coverage available through the individual market is costly and often excludes services that are essential to women's health – a situation that will be exacerbated by SB 142.

Finally, regardless of whether they have health insurance or not, women are more likely than men to report problems getting health care due to cost. On average, women have lower incomes than men, and a greater share of their income is consumed by out-of-pocket health care costs. Both insured and uninsured women are more likely to delay or avoid getting the care they need because they cannot afford it, and they are also more likely to struggle with medical debt or bills or access publicly-funded assistance to meet their medical needs. Health plans that do not provide comprehensive benefits or that shift more costs to women and their families will only make this situation worse.

SB 142 seeks to reverse the progress made in Montana through our non-gender insurance law – a law that is considered a model in the healthcare reform movement of what all states should adopt to assure comprehensive and equitable coverage. Our unique law leveled the playing field for women by providing the mechanism to include women-specific benefits such as maternity care and contraceptive coverage and broadening the pool of risk so that Montana women and families could afford the health insurance that meets their needs.

Please oppose SB 142.

REPORT HIGHLIGHTS

Over the past few decades, considerable progress has been made in improving women's health and in understanding women's unique roles in the health care system. The importance of health care cuts across all aspects of women's lives. Without good access to health care, women's ability to be productive members of their communities, to care for themselves and their families, and to contribute to the work force is jeopardized. As health care has moved to the forefront of the public policy arena, women are increasingly recognizing that they have much at stake in national health policy debates.

To better understand how women are faring in the health care system, particularly groups of women who have historically experienced barriers to care, the Kaiser Family Foundation conducted its first survey of women and their health in 2001. This survey was expanded and repeated in 2004 to delve deeper into women's experiences and further explore some of the challenges they face in their interactions with the health care system. The sample of the survey was also expanded to include women 65 and older, a vital and growing segment of the population in the U.S. The findings presented in this report are based on a nationally representative sample of 2,766 women ages 18 and older interviewed by telephone in the Summer and Fall of 2004. A shorter survey of 507 men was conducted for comparative purposes.

The 2004 Kaiser Women's Health Survey provides the latest data on major areas of women's health policy, including women's demographics, health status, insurance coverage, access to care, health care costs, relationships with providers, and family health issues. Across all of these areas, several key findings have emerged:

Women's health needs and health care utilization patterns change and evolve as they age. Over the course of women's lives, their use of the health care system reflects their changing health needs, from a focus on reproductive health in their younger years to an emergence of more chronic illnesses in the middle years, to higher rates of disability and physical limitations during the senior years.

- Most women in the U.S. are in good health with eight in 10 reporting excellent, very good, or good health. However, a sizable minority—nearly one in five (19%)—are in fair or poor health. This proportion increases with age, to nearly one-third of women 65 and older.

- Nearly four in 10 women (38%), have a chronic condition that requires ongoing medical attention, compared to 30% of men. Not surprisingly, incidence of chronic conditions increases with age. Nearly six in 10 women in their senior years are dealing with hypertension (58%) and arthritis (61%), and almost half with high cholesterol (45%).

- Many younger women also have chronic health problems. By the time women reach their middle years (45 to 64), three in 10 already have high cholesterol and arthritis, and even one in 10 women of reproductive age (18 to 44) say they have arthritis, hypertension, high cholesterol, and asthma or other respiratory condition.

- Women's health needs are also reflected in their provider choices. Virtually all elderly women (95%) have a regular provider, compared to three-quarters of women ages 18 to 44 and 90% of women 45 to 64. As they age, women are also less likely to visit an Ob-Gyn regularly. Only one-quarter (26%) of senior women report a gynecological visit in the past year and only 12% count an Ob-Gyn among their regular providers, compared to 47% of women in their reproductive years.

- Mental health is an often overlooked but critical aspect of women's health care. One out of every four women (23%) report they have been diagnosed with depression or anxiety, over twice the rate for men (11%). Even among senior women, who have lower rates than younger women, 16% are affected by these mental health issues.

- Between 2001 and 2004, reported prevalence of certain chronic conditions rose in the non-elderly population. Among the statistically significant changes were the rise in diabetes from 5% to 8% of non-elderly women, anxiety/depression from 21% to 24%, and obesity from 11% to 13%.

Health coverage—public or private—matters for women, yet it does not guarantee access to care. Most adult women have some form of either private or public health insurance. Women without insurance consistently fare worse on multiple measures of access to care, including contact with providers, obtaining timely care, access to specialists, and utilization of important screening tests.

- Nearly one in six non-elderly women (17%) are uninsured, as are 20% of men. Women who are Latinas, low-income, single, and young are particularly at risk for being uninsured.

- Uninsured women are the least likely to have had a provider visit in the past year (67%), compared to women with either private (90%) or public insurance-Medicaid (88%) and Medicare (93%).

- Compared to women with insurance, uninsured women consistently report lower rates of screening tests for many conditions, including breast cancer, cervical cancer, high blood pressure, high cholesterol, and osteoporosis.

- Insured women also face barriers to care, including delaying or sacrificing care they think they need. One in six women with private coverage (17%) and one-third of women with Medicaid (32%) stated that they postponed or went without needed health services in the past year because they could not afford it.

Health care costs are increasingly acting as a barrier to health care for many women. One-quarter of women delay or don't get needed medical care because they cannot afford it. Furthermore, cost-related problems appear to have worsened since 2001. Many women also cannot afford prescription drugs. They do not fill prescriptions or resort to skipping doses and splitting medicines. These problems do not just affect uninsured women, but are also reported by some women with private health coverage.

- Over one-quarter of non-elderly women (27%) say they delayed or went without medical care they believe they needed due to costs, a significantly larger share than in 2001 (24%).

- Women (56%) are more likely than men (42%) to use a prescription medicine on a regular basis, and are also more likely to report difficulties affording their medications. In the past year, one in five women (20%) report that they did not fill a prescription because of the cost, compared to 14% of men. While the problem is greatest for uninsured women (41%), one in six women (17%) with private coverage and nearly one in five women with Medicaid (19%) also say they faced the same barrier.

- One in seven (14%) women also report that they skipped or took smaller doses of their medicines in the past year to make them last longer. Nearly one in 10 women say they have spent less on basic family needs to pay for their medicines.

Certain populations of women experience higher rates of health problems and report more barriers in accessing health care. Women who are poor, sick, uninsured, or a racial/ethnic minority are particularly at risk for experiencing barriers throughout the health system. For many of these women, health care problems exacerbate other challenges.

- Low-income women confront many obstacles to receiving timely health services. One-third say that they delayed or went without needed care in the prior year because they didn't have insurance. Half (52%) of poor women and 38% who are near-poor (100% to 199% of poverty) report they delayed or did not get needed health care because of the cost.

- Medicaid serves the poorest and sickest populations of women. Nearly nine in 10 (87%) women on Medicaid are low-income and one-third (34%) are in fair or poor health.

- Almost one in four women on Medicaid (23%) say they were turned away from a physician because the doctor was not accepting new patients, as did 18% of uninsured and 13% of privately insured women.

- Two-thirds of uninsured women (67%) report delayed/forgone care due to costs, four times as high as women with private coverage or Medicare.

- Uninsured women are the least likely to have a regular provider. Only half of uninsured women (50%) have a regular doctor, compared to 89% of privately insured women.

- Latina women are the least likely to have a regular doctor. One in three also report delaying or going without care in the past year because of cost.

- African American women are at elevated risk for certain health problems. Over one-third (37%) of African American women ages 45 and older report fair or poor health, 57% have arthritis, and 29% have diabetes, significantly higher rates than among white women.

Women who are sick face more obstacles in obtaining health care. Among the most counter-intuitive findings about the health system are the multiple challenges that women in poor health face—including costs, lack of insurance, and limited access to specialists—in obtaining comprehensive health care. These barriers compound sick women's already difficult circumstances, and may worsen their health by delaying detection and treatment.

- One-fifth (22%) of non-elderly women in fair or poor health do not have health insurance.

- Over one-third of women in fair or poor health (37%) say that they delayed or went without care in the past year because they couldn't afford it. One-third (34%) did not fill a prescription because they couldn't afford it and over one in four skipped or reduced doses to make them last longer.

- Compared to women in favorable health (12%), women in poorer health (27%) are twice as likely to report they couldn't get access to specialty medical care.

- One-third (31%) of women in fair/poor health express concern about the quality of care they received in the past year, compared to 18% of women in better health.

- Women in poorer health are also more likely to experience heavy stress from a range of health, economic, and family issues, including health problems of their family members, financial concerns, and career challenges.

Doctor-patient counseling about health risks and health promoting behaviors is lagging. Despite growing attention to the important role of early intervention and healthy behaviors in health promotion and disease prevention, a sizable share of women do not get counseling when they see the doctor.

- Over half of women (53%) cite health care providers as their primary source of health information; the Internet (15%), friends and family (16%), and books (7%) are relied upon to a much lesser extent.

- Despite women's reliance on providers for information, just over half of women (55%) say they have discussed diet, exercise, and nutrition with a doctor or nurse during the past three years.

- Fewer than half of all women report having had conversations about other health behaviors, such as calcium intake (43%), smoking (33%), and alcohol use (20%) with a provider in the past three years.

- Counseling about sexual health is particularly infrequent, even during women's reproductive years. Fewer than one in three (31%) women ages 18 to 44 say that they have talked with a provider about their sexual history in the past three years. Discussion of more specific topics, such as STDs (28%), HIV/AIDS (31%), emergency contraception (14%), and domestic or dating violence (12%) are also very limited.

Screening test rates for mammograms, Pap smears, and blood pressure have fallen slightly since 2001. Breast cancer, cervical cancer, and hypertension are all conditions known to be responsive to early detection and treatment. Screening tests are an important tool for early intervention, yet the use of some tests may be on the decline. Between 2001 and 2004:

- Mammography rates reported by women ages 40 to 64 dropped from 73% to 69%.
- Pap testing rates reported among women ages 18 to 64 fell from 81% to 76%.
- The rate of reported blood pressure checks dropped from 90% to 88% among women ages 18 to 64.

Women are the health care leaders for their families. Women take charge of the vast majority of routine health care decisions and responsibilities for their children, and on top of their everyday family obligations, over one in 10 women care for a sick or aging relative. Meeting these multiple obligations is demanding and leaves many women concerned about meeting all their family and work commitments as well as managing their own health.

- Eight in 10 mothers/guardians say they take on chief responsibility for choosing their children's doctors (79%), taking them to appointments (84%), and ensuring they receive follow-up care (78%). Mothers are also primarily responsible for decisions about their children's health insurance (57%).
- Similar to men, one in four women feel a lot of stress from career (24%) and financial concerns (23%). Women are significantly more likely than men to be very stressed about managing their own health needs and those of their parents.
- One in 10 women (12%), compared to 8% of men, cares for a sick or aging relative, often an ill parent. The majority of caregivers report that they perform a range of tasks, including housework (91%), transportation (83%), and various financial decisions (66%). Many also assist with medical and physical care, such as administering medicines or shots (58%), as well as routine activities such as bathing and dressing (42%).
- Caregivers themselves contend with a host of health challenges. Four in 10 are low-income, nearly half (46%) have a chronic health condition of their own, and one in five non-elderly caregivers are uninsured.
- A sizable share (29%) of caregivers provide assistance full-time, spending more than 40 hours per week as a caregiver. This is even more common among low-income caregivers, 44% of whom report assisting their relative for over 40 hours weekly.

The findings of the 2004 Kaiser Women's Health Survey underscore the high stakes for women in the health care system and reveal some of the system's gaps in meeting women's health needs. One in six non-elderly women is uninsured and faces considerable obstacles in gaining access to health care. The impact of out-of-pocket costs also poses a growing barrier to primary and specialty care for most uninsured women and one in six women with coverage. Furthermore, despite the renewed interest in prevention, the health care system still falls short in providing women with information and care. There appears to be limited conversations with providers about important health behaviors and many women also do not receive recommended screening tests, which can be critical for early detection and prevention of future disease.

Access to health care is a linchpin for women's economic and health security and family well-being. As policymakers, providers, patients, advocates, and researchers develop strategies to strengthen the health care system, it is critical that they recognize women's central role in the system and how much is at stake for women as a consequence of their decisions.